UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

BRIAN A. PATTERSON,
Plaintiff,

vs. Case Number 24-CV-585pp

HSU MANAGER CANDACE WHITMAN, *et al.*,
Defendants.

EXHIBIT APPENDIX

1. November 24, 2023, DOC-3035.....1
2. December 14, 2023, DOC-3035.....2
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9. April 5, 2024, Defendant Whitman's DOC-3484.....9
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Pursuant to 28 U.S.C. §1746, I verify under the penalty of perjury that all of the appended documents are true and accurate copies of the originals.

Dated this 30th day of August, 2024.

Brian Patterson

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

é NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY ⇦

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
PATTERSON	BRIAN	570847
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
FLCI	4	11·24·23

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE — DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☐ OTHER:

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

THE ICE PACK AND IBUPROFIN THAT I WAS PRESCRIBED FOR THE PAIN IN MY SHOULDER FROM THE FLU SHOT IS NOT WORKING. MY SHOULDER STILL HURTS AND IS TENDER AND I CAN'T SLEEP ON IT.

DATE RECEIVED: TO BE STAMPED BY HSU

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☒ Scheduled to be seen in HSU ☐ ACP ☒ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

I will schedule you to be seen & place a no rec restriction to prevent any further injury

PRINT STAFF NAME — DATE OF HSU RESPONSE

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

⇨ NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY ⇦

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
FACILITY NAME	HOUSIN	TODAY'S DATE

COPAYMENT DISBURSEMENT REQUEST SECTION

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- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE | DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☐ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☐ OTHER:

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

I am experiencing Pain and movement issues in my Right Shoulder despite the exercises and ice pack that was prescribed. I also have Scars on my Right Side.

DATE RECEIVED: TO BE STAMPED BY HSU

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

PRINT STAFF NAME (Blinded) | DATE OF HSU RESPONSE

DISTRIBUTION: Original – Health Services Unit Patient Health Record; Copy – Inmate Official Record – Business Office File; Copies (2) – Inmate Patient

EX 2

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

⇨ NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY ⇦

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
PATTERSON	BRIAN	570847
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
FCI	4C	12.14.23

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

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- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE | DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☐ OTHER:

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

I AM STILL EXPERIENCING PAIN AND MOVEMENT ISSUES WITH MY RIGHT SHOULDER DESPITE THE EXERCISES, MEDS, AND ICE PACK THAT WAS PRESCRIBED. I ALSO CANNOT SLEEP ON MY RIGHT SIDE.

DATE RECEIVED: TO BE STAMPED BY HSU
RECEIVED
DEC 15 2023

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE — TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

~~☐~~ Scheduled to be seen in HSU ☐ ACP ~~☐~~ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

Time is what is needed to allow healing. Received notice you have been playing basketball and working. Can provide both work and Rec restrictions if needed. Please let HSU know. -Christman HSM

PRINT STAFF NAME

A. Ziegler RN

DATE OF HSU RESPONSE

12-15-23

DISTRIBUTION: Original – Inmate Paper Record; PR Patient Request Entry; Official Record – Business Office File; Copies (2) – Inmate Patient

EX 3

Assessment Forms

Location :	Shoulder, right
Assessment :	Unremarkable
Range of Motion :	Limited motion, active, Limited motion, passive
	Quass, RN, Erin K - 12/19/2023 13:01 CST

Nursing Protocols v.2.copay

Nursing Protocol Initiated : Musculoskeletal

Nursing Interventions and Actions: : Pt seen today for f/u right shoulder pain. Pt has been seen twice before and reports no relief with any nursing protocols and that his shoulder feels like "a hinge that needs to be oiled". Pt does not care to take medications and is wondering about possible PT or further treatment. Pt referred to provider and in agreement with POC.

Apply Copay Charge? : No

Quass, RN, Erin K - 12/19/2023 13:01 CST

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

⇨ NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY ⇦

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
PATTERSON	BRIAN	570847
FACILITY NAME	HOUSING UNIT	TODAY'S DATE
FLCI	4C	12.20.23

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE | DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☐ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☐ OTHER:

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

CAN I PLEASE GET A TINS UNIT AND A BOTTLE OF VITAMIN D TABLETS TO SEE IF ONE OR BOTH WILL ~~DISCONTINUE~~ ALLEVIATE THE PAIN IN MY RIGHT SHOULDER? THANKS.

DATE RECEIVED: TO BE STAMPED BY HSU

RECEIVED

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

Vit D would have nothing to do with pain. You do not have an order for either. You do have an order to see the MD for shoulder discomfort.

PRINT STAFF NAME: Terry Kiser DW | DATE OF HSU RESPONSE: 12-21-23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

Patient: **PATTERSON, BRIAN A**
Location: Fox Lake Correctional Institution
Medical Records From:

MRN/DOC#: 000570847
Admission Date: 4/6/2011
to 3/15/2024 08:40 CDT

DOB: 5/31/1976
Discharge:
Gender: Male

Progress Notes

Document Type:	Progress Note Generic
Service Date/Time:	1/23/2024 07:08 CST
Result Status:	Auth (Verified)
Document Subject:	Appointment Cancelled
Sign Information:	Denneau,APNP,Amy (1/23/2024 07:15 CST)

/Mr. Patterson was scheduled to see me today for follow up 12/19/2023 RN Sick call c/o right shoulder pain after receiving the influenza vaccine on 11/15/2023. He was was initially seen by nursing on 11/29/2023 and reported soreness and decreased ROM in right arm. Provided ROM. He was again seen by nursing on 12/19/2023 for follow up and reported he does not care to take medications and is wondering about possible PT or further treatment. No additional HSR or nursing visit documented in the EMR. Writer ordered functional observation. Order placed to follow up with nursing.

Electronically Signed on 01/23/24 07:15 AM

Denneau, Amy APNP

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
Division of Juvenile Corrections
DOC-3332D (Rev. 2/2019)

WISCONSIN

FUNCTIONAL OBSERVATION

PATIENT NAME (Last, First)	DOC #	AGE	UNIT	FACILITY
Patterson, Brian -	570847	47	4C	FLCI

SELF-ABILITY (Able to do Act Independently)			SPECIFY LIMITATION / COMMENTS (If not able to do independently)
Observed to shower / bathe	☒ Yes	☐ No	
Observed to dress	☒ Yes	☐ No	
Observed to use restroom	☒ Yes	☐ No	
Observed to do own hygiene (brush teeth, groom, etc.)	☒ Yes	☐ No	
Observed to obtain food tray	☒ Yes	☐ No	
Feeds self	☒ Yes	☐ No	
Observed to clean room	☒ Yes	☐ No	
Observed to do laundry	☒ Yes	☐ No	
Observed to climb stairs	☐ Yes	☒ No	
Observed to walk on / off unit	☒ Yes	☐ No	
Steady when walking	☒ Yes	☐ No	
Able to sit / stand / move without support	☒ Yes	☐ No	
Ambulatory – able to walk	☒ Yes	☐ No	
Obvious signs of pain (facial grimacing, moaning or groaning)	☐ Yes	☒ No	
Fall History – last six (6) months	☐ Yes	☒ No	
Observed consistently using equipment provided (cane, walker, etc.)	☐ Yes	☐ No	
Other (list):	☐ Yes	☐ No	

IMPAIRMENTS (Has identifiable difficulty with any of the following – check all that apply):

☐ Vision ☐ Hearing ☐ Speech ☐ Memory

RECREATION ACTIVITIES (Check all that patient actively participates in):

☒ Walking	☐ Basketball	☐ Volleyball	☐ Baseball / Softball	☐ Exercise Bike	☐ Yoga
☐ Jog / Running	☐ Weight Lifting	☐ Handball	☐ Treadmill	☐ Card / Board Games	☐ Soccer
☐ Zumba	☐ Stretching	☐ Other (list):			
☐ Hobby (list):					

RESTRICTION SPECIAL NEED RECOMMENDATION / COMMENTS (Provide recommendations for unit restrictions that would enhance functioning):

Unit reports pt has been working in servery with no complaints & is able to perform job.

UNIT STAFF NAME (print or write legibly)	UNIT STAFF SIGNATURE	DATE SIGNED
Ckuehn	Kimball	2.1.24

RETURN COMPLETED FORM TO SPECIAL NEEDS COMMITTEE FOR REVIEW

3-30-24 To HSU manager for review. (S. Buwalda)

ISTRIBUTION: Original – Internal Paper Record, PR Correspondence Letters Section

Assessment Forms

Kuehn, RN, Casey J - 2/1/2024 13:07 CST

Respiratory
Respirations : Unlabored, Quiet

Kuehn, RN, Casey J - 2/1/2024 13:07 CST

Musculoskeletal
Musculoskeletal Assessment : Change from patient's baseline
Musculoskeletal Activity : Independent

Kuehn, RN, Casey J - 2/1/2024 13:07 CST

Musculoskeletal Joint Assessment Grid

Location :	Shoulder, right
Assessment :	Unremarkable
Range of Motion :	Limited motion, passive
	Kuehn, RN, Casey J - 2/1/2024 13:07 CST

Nursing Protocols v.2.copay
Nursing Protocol Initiated : Musculoskeletal
Nursing Interventions and Actions: : Patient presents to HSU with a steady gait requesting evaluation for right shoulder pain, following vaccine administration. Patient walks to exam room, and removes coat with use of both arms, independently and with no observable signs of pain such as groaning, moaning, or wincing. Patient states that it is just getting no better and he cant lift his arm in front of him higher than his shoulder. When patient puts arm in front of him, he raises it to shoulder level. When this RN attempted to lift hand slightly further, I was med with resistance. Patient states he has been doing his exercises but nothing is helping improve it,. Patient encouraged to continue POC and monitor for improvement. Advised I would speak with HSU management about next step. Patient verbalized understanding. Funtional observaion completed with unit, where CO reports patient works in the servery which is "one of the most labor intensive jobs we have." Adviesed patient washes large pans, wipes tables, and never appears uncomfortable. Advises his job does require him to do some lifting and patient has never complained or brought any concerns to CO's attention. Information gathered forwarded to HSUM
Apply Copay Charge? : No

Kuehn, RN, Casey J - 2/1/2024 13:07 CST

TO HSU Manager for review 3/30/24
SBurwalda RN

EX 8

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
Division of Community Corrections
Division of Juvenile Corrections
DOC-3484 (Rev. 12/2023)

WISCONSIN
Federal Regulations
45 C.F.R. § 164.526

REQUEST BY CURRENT PATIENT FOR AMENDMENT/CORRECTION OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First)	DOC NUMBER
PATTERSON, BRIAN	570847

STEP I: TO BE COMPLETED BY PATIENT

Instructions to Patient: You have the right to ask DOC to change specific Protected Health Information (PHI), that you think is incorrect, in identified document(s) in your paper DAI Health Care Record, paper DJC Health Care Record, paper DCC Mental Health Record or Electronic Medical Record. In the space below, explain what specific PHI you think should be changed on the attached document(s), or described document(s). You must include the name/title and date of each document. Attach additional pages to explain your request, if needed. Do not use this form to request amendment or correction of more than one alleged inaccuracy of PHI. This form may be used for more than one document containing the same alleged PHI inaccuracy.

After completing Step 1, if you are an inmate you must give this form to the Health Services Unit, Dental Services Unit or Psychological Services Unit, depending on the part of your Health Care Record that contains the alleged PHI inaccuracy. If you are on DCC supervision, give this form to the DCC psychologist.

A DOC health provider will complete Steps 2 and 3, and return the form to you. See instructions for completion of Step 4 below.

On 12/19/23, I received a photocopy of Form DOC-3035 that I submitted to HSU on 12/14/23. This photocopy had a handwritten comment from HSU Manager C. Whitman that she "Received notice" that I "have been playing basketball." This information is untrue because the prior nurse who evaluated me placed me on rec restriction so I did not and have not been to rec since before 11/14/2 In fact, I am gaining weight because I cannot participate in the rec activiti (handball and basketball) that I used to because of the pain and movement issues in my right shoulder.

Forwarded copy to HSU Manger

RECEIVED
DEC 29 2023
BY

SIGNATURE OF PATIENT

DATE SIGNED
12/28/23

STEP 2: TO BE COMPLETED BY SUPERVISOR REVIEWING PATIENT REQUEST

Instructions to DAI Health Services Manager, Dentist or Psychology Supervisor, or DCC Psychologist: Check the applicable box below.

- ☒ PHI was created by a current DOC health care provider. Forward this form to that provider within ten (10) calendar days, for completion of **Step 3**.
- ☐ PHI was created by a former DOC health care provider. Forward this form to the appropriate Supervisory staff within ten (10) calendar days, for completion **Step 3**.
- ☐ PHI was **not** created by a DOC health care provider. Forward this form to the inmate patient within ten (10) calendar days who will contact the non-DOC health care provider.
- ☐ Return form to patient because **no** specific document(s) were attached or described

NAME OF EMPLOYEE REVIEWING REQUEST	DATE SENT TO PATIENT/ PROVIDER
L. Albrecht	1/2/24

DISTRIBUTION: Original: Inmate Paper Record, PR HIPAA
PSU scan to PR Psychological HIPAA

STEP 3: TO BE COMPLETED BY DOC HEALTH CARE PROVIDER

Instructions to health provider: Review the patient request in Step 1, and the disputed document(s) to determine whether the PHI is accurate. The health provider who created the document shall complete Step 3, except when the provider is no longer a DOC employee. In that situation, a supervisory health provider shall complete Step 3. Forward this form to the patient **within 60 days** of the request. Attach supporting documents, as needed. Indicate in the Approved or Denied section(s), whether all or part of the request(s) is/are approved or denied. In Denial section check the appropriate **Reason for Denial** box. Explain partial approvals or denials in Comments area.

☐ **APPROVED** A copy of the amended/corrected document(s) is/are attached. **(check appropriate box below)**

☐ Entire request ☐ Part of request

☒ **DENIED (check appropriate box below)**

☐ Entire request ☐ Part of request

REASON FOR DENIAL (check appropriate box below)

☒ PHI is accurate and complete. (check appropriate box below)

☒ Reviewed by creator of the PHI. ☐ Reviewed by other health provider because creator is no longer a DOC employee.

☐ PHI is not part of your Health Care Record (designated record set).

☐ PHI was compiled in anticipation of or for use in a civil, criminal or administrative proceeding.

☐ PHI is subject to Clinical Laboratory Improvements Amendments of 1988 that prohibits access by the patient.

Comments:

PRINT NAME OF HEALTH CARE PROVIDER	SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED
Candace Whitman		1/4/24

STEP 4: TO BE COMPLETED BY PATIENT

Instructions to Patient When Request is Denied: When DOC has denied in whole or part your request for amendment, you have the right to submit a "Statement of Disagreement". If you wish to do so, enter your statement in the box below, or check the box saying you do NOT wish to submit a statement. Submit the form to the HSU, PSU or DSU, or to the DCC psychologist. If you submit a "Statement of Disagreement" with attached documents, DOC will disclose this form and the documents with a future disclosure of the disputed document. DOC may write a written rebuttal to your statement in Section 5, and provide a copy to you. If you do NOT wish to submit a "Statement of Disagreement", please tell DOC if you want this form attached to future disclosures of the disputed document.

☒ Yes - Attach this form to future disclosures ☐ No – Do not attach this form to future disclosures

Statement of Disagreement by Patient: ☐ Check if you do NOT want to submit a statement.

Candace Whitman knowingly and intentionally placed the disputed false info into my medical file in order to justify denying me medical care for the injury her subordinate Casey Kuehn caused to my right shoulder on 11/15/23. It is unfounde

Instructions to Patient When Request Approved ONLY: When DOC has approved, in whole or part, your request for amendment, tell DOC which of the amended documents, if any, you want DOC to forward to persons whom you believe have copies of the original document. List the individuals name and addresses on another attached sheet of paper.

RECEIVED
MAR 29 2024
By

☐ Yes, send amended documents listed on attached page to the names/addresses provided. ☐ No, do not send amended documents.

STEP 5: REBUTTAL STATEMENT BY HEALTH PROVIDER

Instruction: DOC may prepare a written Rebuttal statement to the patient "Statement of Disagreement" above in Step 4.

☐ Yes, see Rebuttal statement below ☐ No, DOC will not prepare a Rebuttal statement

The response on the HSR dated 12/14/23 shared information that was provided by 2 separate officers that work in recreation. Medical care was not denied or impacted by that information but rather you were provided available options to promote healing. Etiology of shoulder pain is unknown

PRINT NAME OF HEALTH CARE PROVIDER	SIGNATURE OF HEALTH CARE PROVIDER	DATE SENT TO PATIENT
Candace Whitman HSM		4-5-24

DISTRIBUTION: Original – Internal Paper Record, PR HIPAA, PSU scan to PR Psychological HIPAA

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
Division of Community Corrections
Division of Juvenile Corrections
DOC-3484 (Rev. 12/2023)

WISCONSIN
Federal Regulations
45 C.F.R. § 164.526

REQUEST BY CURRENT PATIENT FOR AMENDMENT/CORRECTION OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First)	DOC NUMBER
PATTERSON, BRIAN	570847

STEP 1: TO BE COMPLETED BY PATIENT

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After completing Step 1, if you are an inmate you must give this form to the Health Services Unit, Dental Services Unit or Psychological Services Unit, depending on the part of your Health Care Record that contains the alleged PHI inaccuracy. If you are on DCC supervision, give this form to the DCC psychologist.

A DOC health provider will complete Steps 2 and 3, and return the form to you. See instructions for completion of Step 4 below.

On February 1, 2024, Nurse Casey Kuehn fabricated DOC-3332D and HSU Assessmen (EMR) based on her alleged communication with Unit 4 Sgt Kimball. Kuehn also forged Sgt Kimball's name on DOC-3332D. (both forms are attached). Sgt Kimbal adamantly denies talking to Kuehn or anyone else from HSU regarding the enclosed false documents. Moreover, Sgt Kimball indicated that he will verify that he never talked to Kuehn or anyone else from HSU regarding these documen HSU staff are falsifying information and placing it into my medical file in order to justify denying me medical care for an injury that Kuehn caused to m right shoulder on November 15, 2023.

Forwarded to HSU manager for review 3/30/24 (S. Buwalda)

SCANNED

SIGNATURE OF PATIENT	DATE SIGNED
	March 29, 2024

STEP 2: TO BE COMPLETED BY SUPERVISOR REVIEWING PATIENT REQUEST

Instructions to DAI Health Services Manager, Dentist or Psychology Supervisor, or DCC Psychologist: Check the applicable box below.

- [x] PHI was created by a current DOC health care provider. Forward this form to that provider within ten (10) calendar days, for completion of **Step 3**.
- [ ] PHI was created by a former DOC health care provider. Forward this form to the appropriate Supervisory staff within ten (10) calendar days, for completion **Step 3**.
- [ ] PHI was **not** created by a DOC health care provider. Forward this form to the inmate patient within ten (10) calendar days who will contact the non-DOC health care provider.
- [ ] Return form to patient because **no** specific document(s) were attached or described

NAME OF EMPLOYEE REVIEWING REQUEST	DATE SENT TO PATIENT/ PROVIDER
C Whitman HSM	4/5/24

DISTRIBUTION: Original – Internal Paper Record PR HIPAA
PSU scan to PR Psychological HIPAA

EX 10

STEP 3: TO BE COMPLETED BY DOC HEALTH CARE PROVIDER

Instructions to health provider: Review the patient request in Step 1, and the disputed document(s) to determine whether the PHI is accurate. The health provider who created the document shall complete Step 3, except when the provider is no longer a DOC employee. In that situation, a supervisory health provider shall complete Step 3. Forward this form to the patient **within 60 days** of the request. Attach supporting documents, as needed. Indicate in the Approved or Denied section(s), whether all or part of the request(s) is/are approved or denied. In Denial section check the appropriate **Reason for Denial** box. Explain partial approvals or denials in Comments area.

☐ **APPROVED** A copy of the amended/corrected document(s) is/are attached. **(check appropriate box below)**

☐ Entire request ☐ Part of request

☒ **DENIED (check appropriate box below)**

☐ Entire request ☐ Part of request

REASON FOR DENIAL (check appropriate box below)

☒ PHI is accurate and complete. (check appropriate box below)

☒ Reviewed by creator of the PHI. ☐ Reviewed by other health provider because creator is no longer a DOC employee.

☐ PHI is not part of your Health Care Record (designated record set).

☐ PHI was compiled in anticipation of or for use in a civil, criminal or administrative proceeding.

☐ PHI is subject to Clinical Laboratory Improvements Amendments of 1988 that prohibits access by the patient.

Comments: This information provided is accurate.

PRINT NAME OF HEALTH CARE PROVIDER	SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED
Casey Kuehn	Casey Kuehn	4/7/24

STEP 4: TO BE COMPLETED BY PATIENT

Instructions to Patient When Request is Denied: When DOC has denied in whole or part your request for amendment, you have the right to submit a "Statement of Disagreement". If you wish to do so, enter your statement in the box below, or check the box saying you do NOT wish to submit a statement. Submit the form to the HSU, PSU or DSU, or to the DCC psychologist. If you submit a "Statement of Disagreement" with attached documents, DOC will disclose this form and the documents with a future disclosure of the disputed document. DOC may write a written rebuttal to your statement in Section 5, and provide a copy to you. If you do NOT wish to submit a "Statement of Disagreement", please tell DOC if you want this form attached to future disclosures of the disputed document.

SCANNED

☒ Yes - Attach this form to future disclosures ☐ No – Do not attach this form to future disclosures

Statement of Disagreement by Patient: ☐ Check if you do NOT want to submit a statement.

I showed SGT Kimball the enclosed documents again on 4/11/24 and he said the same thing he said on 3/18/24: the information attributed to him is FALSE and the documents FORGED. He said call or email him and he'll tell you the same.

Instructions to Patient When Request Approved ONLY: When DOC has approved, in whole or part, your request for amendment, tell DOC which of the amended documents, if any, you want DOC to forward to persons whom you believe have copies of the original document. List the individuals name and addresses on another attached sheet of paper.

☐ Yes, send amended documents listed on attached page to the names/addresses provided. ☐ No, do not send amended documents.

STEP 5: REBUTTAL STATEMENT BY HEALTH PROVIDER

Instruction: DOC may prepare a written Rebuttal statement to the patient "Statement of Disagreement" above in Step 4.

☒ Yes, see Rebuttal statement below ☐ No, DOC will not prepare a Rebuttal statement

Documentation was completed in real time & is detailed information, gathered from unit.

PRINT NAME OF HEALTH CARE PROVIDER	SIGNATURE OF HEALTH CARE PROVIDER	DATE SENT TO PATIENT
Casey Kuehn	Casey Kuehn	4/15/24

DISTRIBUTION: Original -- Internal Paper Record, PR HIPAA, PSU scan to PR Psychological HIPAA